STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 16,432
	)	
Appeal of	)	
	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Prevention, Assistance, Transition and Health Access (PATH), formerly the Department of Social Welfare (DSW), denying him coverage under Medicaid for services and adaptive equipment necessary for him to achieve financial self-reliance. Due to the failure of the Department to furnish the petitioner with timely and complete copies of his medical record, the facts in this matter are found to be those alleged in the following documents submitted to the Board by the petitioner: A "Report of Neuropsychological Evaluation" of the petitioner performed on January 27 and February 4, 2000, and filed with the Board on April 28, 2000; a "Disability Statement" (including addendum) filed on June 12, 2000; and a "Revised Statement of Particulars" and "Summary Statement", filed on July 11, 2000.

DISCUSSION

I.

As the petitioner points out, this is his third appeal of the denial by various agencies of his request for certain services and adaptive equipment alleged to be necessary to his gaining and maintaining employment. (As noted above, for the purposes of this appeal only, it is presumed that the requested services and equipment are, in fact, necessary for the petitioner's employment.) Appeals by the petitioner of decisions by the Division of Vocational Rehabilitation (VR) and the Vermont Department of Employment and Training (DET) have been unsuccessful to date (see infra). The issue in the instant appeal is whether any or all of the services and equipment requested by the petitioner are covered under Medicaid.

The purpose of the Medicaid program, as set forth in Medicaid Manual (MM) § M101 and in the federal statutes at 42 U.S.C. § 1396, is:

> . . . as far as practicable, under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and beneficiaries attain or retain the capability for independence and self-care. . . .

A basic requirement for coverage of any service or item under Medicaid is that it be "medically necessary". MM § M100. The petitioner has requested certain services and equipment that will presumably lead to his becoming economically "self-reliant". While it can certainly be argued that achieving and maintaining economic self-reliance can be beneficial to one's overall health, the petitioner has not shown that the Medicaid law requires the Department to fund his requests for services and equipment that are primarily vocational in nature, rather than medical. Thus, it is concluded that the term "rehabilitation" as used in the Medicaid regulations refers strictly to medical, rather than vocational, rehabilitation.

II.

Taking the petitioner's specific requests for Medicaid coverage in the order presented in his "Revised Statement of Particulars", the petitioner first requests "ongoing case management" by a psychologist. This is related to a specific recommendation in the "Report of Neuropsychological Evaluation" attached hereto (id. p. 8). However, it is clear from the express language in that report that the scope and intent of the recommendations contained therein are "for the purpose of educational planning and vocational rehabilitation" (id. p. 1). The petitioner has not shown that such services are recommended

or necessary to improve or maintain any medical condition. Thus, it cannot be concluded that this service must be covered as a "licensed psychologist" service under MM § M660.

Nor can it be considered a home health agency service under §§ M710 et seq. Those services are expressly limited to when a patient has "an acute illness or injury or a chronic condition requiring home health care under a physician's order" (§ M710.4[1]).

The same analysis pertains to the petitioner's request for "language evaluation and therapy". The petitioner has not cited any medical need for such therapy. Under the regulations, occupational and speech therapy are covered only under the same conditions as other home health services (see § M710.4[1], supra).

Similarly, the petitioner's request for a "personal aid" fails to state a medical need. Even if it did, however, the regulations state that "personal care services are not covered for recipients age 21 and older" (§ M740.2).

The petitioner has also requested coverage for a "low distortion sound recorder and wireless microphone", "noise reduction and noise cancellation equipment", and a "laptop computer". He argues that such devices should be considered either "augmentative communication devices/systems" within the

meaning of §§ M842 et seq. of the Medicaid regulations or "prosthetics" within the meaning of §§ M843 et seq. Again, however, the basis of the petitioner's request for these devices is his vocational need for such equipment rather than a medical one. Section M842.4 of the regulations provides that augmentative communications devices are covered only "when the impairment prevents writing, telephone use, or talking", and only if they "will be used to meet specific medical objectives or outcomes" (emphasis added). It cannot be concluded that the regulation requires coverage when such devices are used primarily for vocational purposes.

Similarly, § M843.4 of the regulations provides that "prosthetic devices must be prescribed by a physician or podiatrist"; and § M843.6 specifies that there is no coverage under Medicaid for "orthotics/prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need".

The petitioner's requests for a "specially configured personal computer" and an "ergonomic keyboard with wrist supports", being primarily to meet vocational rather than medical needs, also do not meet the regulatory criteria for coverage as either augmentative communication devices or prosthetics. For the same reason (i.e., that the need for them

is primarily vocational rather than medical) they do not qualify for coverage as "durable medical equipment". Section M840.1 includes in the definition of durable medical equipment the requirement that such equipment be "primarily and customarily used to serve a medical purpose".

The petitioner also requests Medicaid coverage for "transportation" to job-related training and therapy sessions. Again, however, the regulations specifically require that covered transportation be "to and from necessary medical services" (§ M755[3]).

III.

Under "eyeglasses and vision care services" the petitioner requests the following: "second pair of reading glasses", "robust frames", "eyeglasses for class", and "protective eyeglasses". Unlike the above items, eyeglasses are covered under Medicaid, but only on a limited basis. Like the items discussed above, the petitioner bases his request for an exemption from the coverage limitations for eyeglasses on the fact that additional eyeglasses are necessary if he is to succeed in vocational training and readiness.

This is essentially the same type of request the petitioner made in a previous fair hearing, No. 15,252, decided by the Board on January 16, 1998. In that case the Board held that

there are no exceptions permitted in the Medicaid regulations to the limit of one pair of eyeglasses every two years per recipient. This decision was consistent with a prior ruling in Fair Hearing No. 15,154, in which the Board held:

> Unlike many provisions in the Medicaid regulations, (the one) involving the number of eyeglasses which will be provided to recipients is clearly spelled out:
>
> > Eyeglasses (frames and lenses) and repairs and replacements are covered under the terms of a sole source contract with the Department of Social Welfare. Coverage is limited to one pair of eyeglasses every two years per recipient.
>
> M670
>
> The regulations express no further exceptions to this rule. The petitioner may have made a compelling argument that there should be an exception to this policy but he has made no argument that such an exception is legally required. Without the latter, the Board cannot require the Department to make an exception to its rules. The Board cannot rewrite the rule itself to grant an exception merely because it disagrees with the Department.

The limitation in § M670 of one pair of eyeglasses every two years per recipient has not been changed. Inasmuch as the Department has already provided the petitioner with one pair of eyeglasses within the last two years, there remains no basis in the regulations under which the petitioner can qualify for any other pairs.

IV.

The petitioner has also requested Medicaid coverage for a "therapeutic mattress" and for an examination by an orthopedic specialist for recurring hip pain. Unlike all the previous requests discussed above, his requests for a therapeutic mattress and an orthopedic exam do not appear to be based on a vocational need, but rather on a medical and personal one. Unfortunately the hearing officer must admit that these requests were "lost in the shuffle" during his several meetings with the petitioner and the Department in this matter, which focused almost exclusively on the petitioner's vocational claims and procedural grievances. As a result, and in order not to further delay a decision on all the other claims, it is ordered that this aspect of the petitioner's appeal be severed from all the other pending claims discussed above and it is remanded to the hearing officer for further development and consideration.

V.

The petitioner's remaining claims do not concern Medicaid coverage, but rather eligibility and procedural issues. First of these, the petitioner seeks to have his "training and job hunting expenses" deducted from his income as a work-related expense in the financial determination of his eligibility for Medicaid. The petitioner is correct that § M243.1(8) provides

for a deduction from income of "work expenses for the disabled". However, this section makes clear that it is referring only to "deductions from earned income" under § M241.2 (emphasis added). All the petitioner's income is unearned. Unfortunately, there is no provision anywhere in the regulations allowing for the deduction of training or job-hunting expenses from unearned income (see § M242.2).

VI.

Another of the petitioner's grievances beyond the issue of coverage is the failure of the Vermont Health Care Access agency to respond to his request for an "outreach worker" to come to his home or to a mutually-convenient location rather than deal with him exclusively by telephone. The petitioner maintains that his disabilities make telephone contact "ineffective", and that in-person contact is a reasonable accommodation under the Americans with Disabilities Act (ADA). The hearing officer takes this request to mean contacts the petitioner has with the Department's state office in Waterbury, rather than the district office in his hometown, which appears to be readily accessible to the petitioner. Although it is not clear what ongoing contacts with the Department's state office may be required by the petitioner, his request is certainly worthy of consideration by the agency. Therefore, it is ordered that on remand of this

matter the Department shall respond in writing to this request by the petitioner; and, if it is denied, the Department should be directed to advise the petitioner of his appeal rights under ADA.[1]

VII.

The last issue raised by the petitioner appears to be a question as to the timing of the Department's reviews of his eligibility. On April 11, 2000 the Department sent the petitioner a notice stating that his eligibility for Medicaid would end on May 31, 2000, and that he would not be eligible for a new period of coverage until he had "reapplied and given proof that your medical expenses will be more than the amount you are responsible for from your income during any six month period beginning June 1, 2000 or after". The petitioner appears to argue that this action is contrary to the general provision in the regulations that: "Once granted, Medicaid coverage continues until a decision is made to end it because the person (or group) no longer passes all the eligibility tests . . ." (§ M131).

The petitioner's argument overlooks the facts he had previously been granted Medicaid for only a six-month period and that, as a result, at the end of that period he no longer

[1] At this point, it need not be determined whether the Human Services Board would have jurisdiction over such an appeal.

automatically met the eligibility tests. The Department's notice was timely and it fully apprised the petitioner of what he had to do to become eligible again. The Department's decision in this regard is entirely consistent with the provisions of § M132 regarding "review frequency".

VIII.

As noted above, the petitioner was unsuccessful several years ago in an appeal involving the Division of Vocational Rehabilitation (see Zingher v. Dept. of Aging and Disabilities, 163 Vt. 566 (1995). In its January 1998 decision in Fair Hearing No. 15,252 regarding the petitioner's prior Medicaid appeal for extra eyeglasses (see supra), the Board noted the following:

> At the hearing the petitioner was advised that the hearing officer does not agree that the decision in his Supreme Court appeal means that he is forever barred from receiving services from the Division of Vocational Rehabilitation, and that he should reapply for Vocational Rehabilitation services if he feels more than one pair of eyeglasses (or any other vocational "service") is essential to his obtaining training or employment. However, inasmuch as the decision by the Department of Social Welfare appears to be in accord with its regulations, that decision must be affirmed.

Sadly, it appears that the same advice would still hold. The "Report of Neuropsychological Evaluation", upon which the petitioner so heavily relies in support of his need for vocational services and equipment is relatively recent. There

is no indication that it has ever been considered in the context of a claim for services from the Division of Vocational Rehabilitation. Again, the petitioner is strongly advised to reapply for services from VR rather than to attempt to bootstrap what is essentially a claim for vocational services onto a program (Medicaid) designed solely to meet medical needs.[2]

ORDERS

1. The petitioner's appeal of the Department's decisions denying him Medicaid coverage for a therapeutic mattress and an examination by an orthopedic specialist is remanded to the hearing officer for further consideration.

2. The petitioner's request for an outreach worker or other accommodation in his dealings with the state office of the Health Access agency is remanded to the Department for full consideration and notification to the petitioner of its decision.

3. The Department's decisions regarding all other claims brought by the petitioner in this appeal are affirmed.

[2] If such an application were denied, the petitioner would have full appeal rights regarding any factual allegation that has arisen since 1995.

RULINGS ON PETITIONER'S MOTIONS

1) The "Emergency Motion for Reconsideration and Joint Adjudication" is denied. The petitioner is free to reapply for Medicaid coverage of any service or item on the basis that it is medically, as opposed to vocationally, necessary. The petitioner should submit medical evidence that addresses such claim.

2) The "Emergency Motion for Appointment of Special Master" is denied. See Fair Hearing Rule No. 8.

3) The Emergency Motion for Discovery is remanded to the hearing Officer for further consideration.

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